

Life Insurance Notice of Claim
Please type or print using dark ink.



Grange Life Insurance Company
Attn: Life Claims Department
PO Box 182828
Columbus, OH 43218-2828
800-399-3797

1. Decedent Information

1. First Name Brian		2. Middle Name Keith		3. Last Name McClain	
4. Street Address 824 Mullins Lane		5. City Benton		6. State KY	7. Zip 42025
8. Date of Birth 11/18/70	9. Date of Death 4/18/23	10. Cause of Death gun shot wound			
11. Policy Number(s) [REDACTED]					

2. Physician(s) Information (only required if the date of death was within 2 years of the policy issue or last reinstatement date) (Please attach additional pages if necessary)

1a. Name of Physician		b. Address			
c. Phone () -	d. Date of Attendance From / / To / /			e. Disease or Condition	
2a. Name of Physician		b. Address			
c. Phone () -	d. Date of Attendance From / / To / /			e. Disease or Condition	
3a. Name of Physician		b. Address			
c. Phone () -	d. Date of Attendance From / / To / /			e. Disease or Condition	

3. Additional Life Insurance (only required if the date of death was within 2 years of the policy issue or reissue date)

1. Name of Company	Amount of Coverage	Date of Policy
1a.		/ /
1b.		/ /